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Recommended Citation

Williamson, Moira and Strahle, Avon: Workforce issues, skill mix, maternity services and the Enrolled Nurse : a discussion 2005, 18-20.
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Workforce issues, skill mix, maternity services and the Enrolled Nurse : a discussion

Abstract

New South Wales (NSW) is experiencing a shortage of registered midwives. Currently midwives are being actively recruited for 125 metropolitan and 45 rural positions in area health services across the state. This shortage of registered midwives is occurring not only in NSW but also throughout Australia, and has also been reported internationally (McKenna & Hasson, 2002; Keeney et al. 2005). In an attempt to address the ongoing shortage of registered nurses and midwives the NSW Health Department has proposed that a skill mix of 80% registered nurses or midwives to 20% enrolled nurses be implemented within hospitals. This initiative will have significant consequences for women and their families receiving care within maternity units and for the midwives who currently deliver that care should this be implemented within Maternity units.

Keywords

nurse, services, discussion, workforce, mix, issues, enrolled, maternity, skill

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

Publication Details

Williamson, MJ and Strahle, A, Workforce issues, skill mix, maternity services and the Enrolled Nurse : a discussion, *Midwifery Matters*, 23(2), 2005, 18-20.

Workforce Issues, Skill Mix, Maternity Services And the Enrolled Nurse **A Discussion**

New South Wales (NSW) is experiencing a shortage of registered midwives. Currently midwives are being actively recruited for 125 metropolitan and 45 rural positions in area health services across the state. This shortage of registered midwives is occurring not only in NSW but also throughout Australia, and has also been reported internationally (McKenna & Hasson, 2002; Keeney et al. 2005). In an attempt to address the ongoing shortage of registered nurses and midwives the NSW Health Department has proposed that a skill mix of 80% registered nurses or midwives to 20% enrolled nurses be implemented within hospitals. This initiative will have significant consequences for women and their families receiving care within maternity units and for the midwives who currently deliver that care should this be implemented within Maternity units.

The aim of this discussion paper is to address issues about the most appropriate health professional to provide care to childbearing women and their families while achieving optimum, cost effective health outcomes.

Enrolled nurses (ENs) receive

minimum (if any) education in regard to the specialised care and support that woman, their babies and families require across the continuum of the childbearing experience. The possible exception to this in NSW are Mothercraft Nurses that registered prior to 1991 and who are currently classified as List B Enrolled Nurses (Mothercraft). There are facilities within NSW that offer enrolled nurses post registration qualifications in Mothercraft, however the NSW Nurses and Midwives Registration Board no longer recognises this as a separate category for registration.

Recent recommendations by the National Nursing and Nursing Education Taskforce (N3ET) make specific reference to the expansion of the scope of practice for ENs and to the emergence of new areas of Enrolled Nursing Specialisation (National Nursing and Nursing Education Taskforce, 2005). As yet no consensus exists in Australia as to the scope of practice of ENs, and this continues to be an area of ongoing debate.

One suggestion is that ENs be educated to diploma level, thereby opening their education programs to the possible inclusion of

maternity care subjects and other areas of specialisation. This has the potential to impact further on the availability of positions for registered and student midwives. A skill mix of 80% midwives to 20% ENs may also be disproportionate within maternity units, as ENs would be most employable within postnatal units. Anecdotally it is well recognised that postnatal units are often not staffed to appropriate levels, as it is assumed that 'normal' new mothers and babies require minimal care. The introduction of ENs to this important, and often neglected area of maternity care, would serve to further undermine the quality of postnatal care. It should also be noted that more women are choosing early discharge from hospital and electing to have postnatal care at home. ENs would be unable to provide this care for women thus restricting women's access to more woman centred models of care.

Midwives have been recognised by key international organisations, including the World Health Organisation and the United Nations, as being the most cost effective and competent practitioners to deliver perinatal care to women in home, community,

primary and secondary health settings within the developed and the developing world. These organisations have also recognised midwifery as a unique profession, independent of nursing.

During times of economic restraint, political pressure and staff shortages, health care systems and organisations are tempted to look for the 'quick fix'. The seemingly cheap and easy solution of 'generic health workers' continues to be debated throughout the USA, UK and Australia - indeed a symposium entitled "Re-engineering the Clinical Workforce: A Generic Solution to the Nursing Shortage" is being held by the Policy and Professional Issues Forum at the School of Nursing, University of Melbourne in May this year. Midwives may soon be called upon to participate in similar debates.

The same arguments are employed to justify the use of 'cheaper' and more speedily trained labour in the form of enrolled nurses in positions that have previously required a registered nurse and/or midwife. Midwives recognise that nurses may be called upon in emergency situations, where no midwife is available, to assist childbearing women. The NSW Midwives Association recently produced an updated version of the popular and widely distributed Maternity Emergency Guidelines for Registered Nurses (2003), as a primary resource for nurses in this situation. This package could be adapted for use by enrolled nurses in similar situations. However, it does not equip either tier of nurse to 'replace' a midwife or midwifery care.

Employing non-midwives in midwifery positions is perhaps false economy for two reasons. Firstly, the short-term financial gains are lost in the resultant poor health outcomes for women and their babies. It can be argued that, in developed countries where midwifery care is absent or restricted, we see the highest rates of intervention and the lowest rates of breastfeeding - both important measures related to long term morbidity. Secondly, a reduction in available midwifery positions will impact on the employment opportunities and recruitment of future midwives thereby amplifying the current shortage.

There are also substantial concerns about the possible introduction of yet another tier of health professionals into maternity services. Of major concern is the impact on the future education of midwives. Currently the majority of midwifery students are undertaking postgraduate qualifications and require clinical placement in maternity services. These students need employment and adequate clinical exposure to ensure that their education meets the requirements of the Registering Bodies. It may be more appropriate for the ratio of skill mix in maternity units to be 80% registered midwives to 20% student midwives, as the majority of current midwifery students are also registered nurses who therefore have professional skills that can be utilised in maternity settings whilst undertaking their midwifery education. However there is great disparity between the numbers of available midwifery student positions, as some maternity units actively recruit and maintain a high pro-

portion of students per birth rate in comparison to others.

If ENs were employed in maternity services, they would need to be supervised by registered midwives - time that could otherwise be spent in teaching and supervising the next generation of midwives. It would be inappropriate to expect postgraduate student midwives to educate and supervise ENs, and would have a significant impact on the quality of care that women receive and on the learning experience of the student midwives.

The first Bachelor of Midwifery (BMid) program in NSW commenced this year. These Bachelor of Midwifery students are undergoing their clinical placement in a supernumerary mode (no reimbursement). Many of these students require employment in addition to their studies to continue to meet the economic costs of the program and their personal needs. Under the NSW Nurses Award, Assistants in Midwifery can be employed. At this stage there are no guidelines as to what duties Assistants in Midwifery would perform. There may be a better understanding of the type of work that could be undertaken by Assistants in Midwifery once the data analysis from BirthRate Plus has been released. However if these positions were filled by BMid students it would place them in an environment that is rich in opportunity to observe and learn and would give them greater exposure to aspects of maternity care.

The education of ENs ceased in the United Kingdom (UK) following the release of the project 2000 report (Kenny & Duckett,

2005). The withdrawal of the EN workforce created a need for Health Care Assistants (HCAs). However, the roles of the EN and HCA are quite different. In the U.K. the role of the HCA is to perform non-nursing duties such as clerical, portering and hotel (bed making, cleaning, reception etc) tasks (Keeney et al, 2005; McKenna et al, 2002). The use of HCAs in the U.K has caused ongoing debate about the effectiveness of this tier of health worker. The role of the HCA is not standardised so it changes from ward to ward and hospital to hospital. There is a concern that for economic reasons HCAs will be utilised by health care providers in preference to more 'costly' registered midwives (Keeney et al, 2005). There is also evidence that midwives and student midwives are performing numerous tasks that do not enhance the most effective utilisation of their time and level of expertise (McKenna et al 2002). It is likely that these results could be translated into a NSW context. Current testing in NSW of Birthrate Plus (BR+), initiated by NSW Health, will throw further light on this issue.

BR+ is a workforce planning and decision making system developed in the UK as a means of determining the number of full time equivalent midwives required to meet the demand for midwifery care in individual maternity services. Currently thirteen maternity units/hospitals in NSW are participating in the BR+ study. The prime purpose of BR+ is to assess the midwifery staff establishment based on clinical indicators that reflect women's needs and expectations. There is recogni-

tion of the additional roles that support and contribute to the provision of care. BR+ takes into account such roles whilst ensuring that quality of care is not compromised and is provided to established safe standards.

The skill-mix in maternity services must meet the needs of women and their families and enable the midwifery profession to grow by providing places for midwifery students. Maternity managers need to understand the implications of replacing registered midwives or filling midwifery vacancies with enrolled nurses as outlined in this discussion paper. We suggest that it would be more appropriate to support the role of new midwifery graduates and midwifery students as part of their midwifery career progression. Under clinical governance it is important that an appropriate skill-mix is utilised to ensure optimal safety for

women and their families and to reduce the risk of costly litigation.

An important question in relation to the current midwifery shortage in NSW is 'why is this happening?' Anecdotally it is well known that hospitals in rural and remote areas have difficulty recruiting both registered nurses and registered midwives. This is often related to the geographical location not being suitable to lifestyle preference and requirements for access to education and family support etc. So, why do we currently have 125 vacancies for registered midwives in metropolitan area health services? Why do some maternity units have an availability list of eligible registered midwives waiting to be employed and other maternity units cannot recruit? Perhaps it is time that we as individual midwives examine the culture of midwifery to ensure that we are providing supportive environments for our colleagues, our students and ourselves. In the words of Bridget Lynch (2002, p. 186):

"Caring for the caregiver includes the way we care for each other as midwives. We need to create situations and relationships where our hearts can be fortified and nourished, not just our minds in academic or peer-reviewed settings. We must not treat ourselves, each other, or the women we serve as machines of productivity."

Midwives and midwifery need to develop long term strategies to ensure the continuation of gold standard care for all women. They must resist the temptation to participate in the bandaid solutions currently being promoted - the long-term health outcomes of women and their babies everywhere depend upon it.

HOW TO GET A SCHOLARSHIP

**NSW Midwives
Association**

*Applications are called for
various scholarship
opportunities for members
of the NSW Midwives
Association.*

*For more information
Phone: 02 9281 9522
or Email:*

admin@nswmidwives.com

*Applications close
30th June 2005.*